

PRINTED: 10/29/2015  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL096045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01  B. WING: _____	(X3) DATE SURVEY COMPLETED  09/16/2015
NAME OF PROVIDER OR SUPPLIER  CAROLINA LIVING ASSISTED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 103 SE RAILROAD STREET PIKEVILLE, NC 27863		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments  Report by Rick Benton & Robin Fay  DHSR Construction Section conducted a Biennial Survey on September 16, 2015 from 9:30 am until 11:15 am at the above referenced facility. DHSR records indicate the home was first licensed on November 2, 2007 as a Family Care Home for five (5) ambulatory Residents (able to evacuate and respond without any physical or verbal assistance during a fire or other emergency). On January 21, 2014, there was a Change of Ownership and a Change in Capacity from 5 to 8 ambulatory residents. Based on this we are requiring the home to be in compliance with the following: the 2005 Rules 10A NCAC 13G for Family Care Homes, and the 2006 Edition of the North Carolina State Building Code - Section 421.2 - Residential Care Homes.  At the time of our visit, we cited deficiencies that require an acceptable plan of correction. They are as follows:	C 000		
C 105	Initial Licensure-Meet NCSBC  SECTION .0300 - THE BUILDING 10A NCAC 13G .0302 DESIGN AND CONSTRUCTION (a) Any building licensed for the first time as a family care home shall meet the applicable requirements of the North Carolina State Building Code. All new construction, additions and renovations to existing buildings shall meet the requirements of the North Carolina State Building Code for One and Two Family Dwellings and Residential Care Facilities if applicable. All applicable volumes of The North Carolina State Building Code, which is incorporated by reference, including all subsequent amendments,	C 105		

CONSTRUCTION SECTION  
NOV 10 2015  
RECEIVEDDivision of Health Service Regulation  
(SIGNATURE OF DIRECTOR OR DESIGNATED REPRESENTATIVE)TITLE November 9, 2015 (X6) DATE  
Kim Crocker RN, Administrator

Kim Crocker RN, Administrator

If continuation sheet 1 of 11

PRINTED: 10/29/2015  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL096045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA LIVING ASSISTED CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 SE RAILROAD STREET PIKEVILLE, NC 27863</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 105	Continued From page 1  may be purchased from the Department of Insurance Engineering Division located at 322 Chapanoke Road, Suite 200, Raleigh, North Carolina 27603 at a cost of three hundred eighty dollars (\$380.00). (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home.  This Rule is not met as evidenced by: 1) During the survey, it was observed that the home was serving at least one non-ambulatory resident. The home is currently classified under Section 421.2 of the 2006 NC Building Code which means it can serve only all ambulatory residents. Since the home is serving non-ambulatory resident(s), the home will have to be reclassified by your Local Building Official to meet the requirements of Section 425.3 of the 2012 NC Building Code. the local building official will have to verify that the home meets all of the following requirements as listed below from section 425.3 and its subsections Section as follows: 425.3.1, 425.3.3, 425.3.5, 425.3.7, 425.3.8 and 425.3.11. Please see the attached copy of code for your references. You will need to contract a qualified technician to make certain modifications and installations under these sections guidelines. Upon completion, provide documentation of the approvals from the local official having jurisdiction and any supporting documentation from the technicians to our office for verification of the completed work.	C 105	C 105 Our desire is to obtain approval for 3 non-ambulatory residents in addition to 3 ambulatory. We have met with the Wayne County Fire Inspector and are in the process of completing revisions to the home as per this document and his instruction. The plan will be completed by November 25, 2015.		
C 174	Building Equipment Maintained Safe, Operating  SECTION .0300 - THE BUILDING 10A NCAC 13G .0317 BUILDING SERVICE	C 174			



PRINTED: 10/29/2015  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL096045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA LIVING ASSISTED CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 SE RAILROAD STREET PIKEVILLE, NC 27863</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 174	<p>Continued From page 3</p> <p>repairs to the window. Provide to this office a picture or receipt from the technician for verification of the completed work.</p> <p>2) During the survey, it was observed that the GFCI when plugged with the tester indicated that the wiring was correct. When the GFCI was tested, it indicated that the GFCI was HOT/NEUTRAL/REVERSE which is indicative of a two wire electrical system. However, there were other electrical outlets that were GFCI protected in the home and they tested as required. Since there are other outlets available, contact a qualified technician to make the necessary repairs to the outlet. Provide to this office a receipt from the technician for verification of the completed work.</p> <p><b>WATER HEATER CLOSET</b></p> <p>1) During the survey, it was observed that a hole existed in the upper left corner of the wall. Contact a qualified technician to make the necessary repairs to the wall. Provide to this office a picture or receipt from the technician for verification of the completed work.</p> <p><b>BEDROOM 1</b></p> <p>1) During the survey, it was observed that there was a ceiling stain and peeling paint along the left side edge of the ceiling when entering the bedroom. Contact a qualified technician to make the necessary repairs to the wall. Provide to this office a picture or receipt from the technician for verification of the completed work.</p> <p>2) During the survey, it was observed that the front facing window in the bedroom did not stay in the up position when opened. Contact a qualified technician to make the necessary adjustments to the affected window. Provide supporting</p>	C 174	<p><b>C174</b></p> <p>The GFCI outlet in Bathroom 2 will be re-wired to work as intended and verification will be provided by November 25, 2015.</p> <p>The hole in the water heater closet has been closed/patched with sheetrock as instructed by the Construction department. Completed as of November 9, 2015. A picture will be provided as verification by November 25, 2015.</p> <p>The stain and peeling paint on the ceiling in Bedroom 1 will be repaired and verification provided by November 25, 2015.</p> <p>The front facing window in Bedroom 1 will be repaired by placing a window stop to ensure it will remain in the up position when opened. This will be completed and verification provided by November 25, 2015.</p>		



PRINTED: 10/29/2015  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL096045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA LIVING ASSISTED CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 SE RAILROAD STREET PIKEVILLE, NC 27863</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 174	Continued From page 5  qualified technician to make the necessary repairs to the window. Provide to this office a picture or receipt from the technician for verification of the completed work.  4) During the survey, it was observed that the left window of the double window in the bedroom did not stay in the up position when opened. Contact a qualified technician to make the necessary adjustments to each affected window. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  5) During the survey, it was observed that the entrance door to the bedroom was not plumb with the door frame. Contact a qualified technician to make the necessary repairs to the door or the frame. Provide to this office a picture or receipt from the technician for verification of the completed work.  HALLWAY 1) During the survey, it was observed that the filter in the return vent was not the proper size for the vent. Arrange for someone to install the proper size filter in the vent. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  RAMPS - NEW AND EXISTING 1) During the survey, it was observed that the home has non-ambulatory residents. In accordance with the licensure rule 10A NCAC 13G .0312 (c), if the home has any resident that must have physical assistance with evacuation the home must have two outside entrances/exits at grade level or accessible by a ramp. Since neither entrance/exit is at grade level and there is only one ramp installed, the provider must contact	C 174	C 174  The window on the left side of the double window of Bedroom 3 will be repaired to stay in the up position when opened, verification will be provided by November 25, 2015.  The door way to Bedroom 3 will be repaired to ensure it is plumb and verification will be provided by November 25, 2015.  Filters in the correct size have been purchased for the return vent in the hallway. Verification of installation will be provided by November 25, 2015.  A ramp has been installed at the front entrance so there are now 2 exit ramps for the home. A picture will be provided as verification by November 25, 2015.	

PRINTED: 10/29/2015  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL096045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA LIVING ASSISTED CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 SE RAILROAD STREET PIKEVILLE, NC 27863</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 174	Continued From page 6  a qualified technician to make the necessary installation of a second ramp at the other entrance/exit of the home. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  2) During the survey, it was observed that at the end of the ramp where the ramp deck terminates at the landing, there is a section of the ramp deck that protrudes upward creating a trip hazard. Contact a qualified technician to make the necessary adjustments to the ramp deck. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  3) During the survey, it was observed that the ramp handrails were slightly loose. Contact a qualified technician to make the necessary adjustments to the ramp handrails. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  BACK PORCH 1) During the survey, it was observed that the back porch and the back steps had no guardrails installed. Contact a qualified technician to make the necessary corrections to the back porch and the back steps. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  FRONT PORCH 1) During the survey, it was observed that on the left side of the front porch the support post wooden wraps and the base caps have deteriorated. Contact a qualified technician to make the necessary repairs to the wooden post and the base caps. Provide supporting	C 174	C 174  The section of the ramp will be repaired to eliminate the trip hazard. A picture for verification will be provided by November 25, 2015.  The handrails of the ramp will be repaired to ensure they are secure and verification will be provided by November 25, 2015.  Guardrails will be installed around the back porch and steps and verification will be provided by November 25, 2015.  The deteriorated wood of the wrap and base caps of the support post on the front porch will be repaired and verification provided by November 25, 2015.	



PRINTED: 10/29/2015  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL096045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA LIVING ASSISTED CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 SE RAILROAD STREET PIKEVILLE, NC 27863</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 174	<p>Continued From page 7</p> <p>documentation such as pictures or receipts to our office for verification of the completed work.</p> <p>2) During the survey, it was observed that on the left side of the front porch just below the support post there is a section of rotted deck fascia board. Contact a qualified technician to make the necessary repairs to the deck fascia board. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.</p> <p>3) During the survey, it was observed that the front porch had several unsecured sections of plank decking. Contact a qualified technician to make the necessary repairs to the unsecured sections of plank decking. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.</p> <p>4) During the survey, it was observed that on the left side of the front porch just above the support post, a section of the soffit was deteriorated. Contact a qualified technician to make the necessary repairs to the section of deteriorated soffit. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.</p> <p><b>EXTERIOR</b></p> <p>1) During the survey, it was observed that a section of aluminum siding above the back porch was peeled back and missing a section. Contact a qualified technician to make the necessary repairs. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.</p> <p>2) During the survey, it was observed that a section of aluminum siding on the rear gable was</p>	C 174	<p>C174</p> <p>The damaged fascia board on the left side of the front porch will be repaired and verification provided by November 25, 2015.</p> <p>The plank decking of the front porch will be secured and verification provided by November 25, 2015.</p> <p>The damaged soffit on the left side of the front porch will be repaired and verification provided by November 25, 2015.</p> <p>The exterior siding at the back porch will be replaced/repared and verification provided by November 25, 2015.</p> <p>The exterior siding at the rear gable will be replaced/repared and verification provided by November 25, 2015.</p>	



PRINTED: 10/29/2015  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL096045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA LIVING ASSISTED CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 SE RAILROAD STREET PIKEVILLE, NC 27863</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 174	Continued From page 8  missing. Contact a qualified technician to make the necessary repairs. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  3) During the survey, it was observed that several sections of aluminum fascia along the back right side, the rear side and along the area above the back porch of the home have rust streaks. Contact a qualified technician to make the necessary repairs. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  4) During the survey, it was observed that several foundation vents along the right side of the home were not installed. Contact a qualified technician to make the necessary repairs. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  5) During the survey, it was observed that the chimney flashing may be compromised as evidence of an interior ceiling stain in bedroom 3. Verify the condition of the flashing. If it has deteriorated, contact a qualified technician to make the necessary repairs. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  REAR OFFICE AREA 1) During the survey, it was observed that the walls in this room did not meet the requirements for one hour protection. Since this portion of the home is not used for anything other than storage, a two hour separation must be installed between this area and the main home. The two hour separation must be verified and approved by the local building inspector. Contact a qualified	C 174	C174  The areas of rust streaks on the exterior fascia on the back right side, rear side and back porch will be corrected and verification provided by November 25, 2015.  Foundation vents will be installed and verification provided by November 25, 2015.  The chimney flashing will be repaired with verification provided by November 25, 2015.  Sheetrock has been installed along the rear wall of Bedroom 4, including closure of the unused doorway, as instructed by the Wayne County Fire Inspector to meet the two hour requirement. The Inspector has completed a rough-in inspection and approved the work thus far and will return when the project is complete for final inspection. Verification of completion will be provided by November 25, 2015.		

PRINTED: 10/29/2015  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL096045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA LIVING ASSISTED CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 SE RAILROAD STREET PIKEVILLE, NC 27863</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 174	Continued From page 9  technician to make the necessary repairs. Provide supporting documentation such as pictures or receipts to our office for verification of the completed work.  2) During the survey, it was observed that the smoke detector emitted a weak signal. Ensure this smoke detector is interconnected to the detectors in the home. Contact a qualified technician to make the necessary repairs. Provide supporting documentation to our office for verification of the completed work.  3) During the survey, it was observed that an access hatch appeared to be bulging and not flush with the ceiling. Contact a qualified technician to make the necessary repairs. Provide supporting documentation to our office for verification of the completed work.  4) During the survey, it was observed that one of the pickets on the railing is broken. Contact a qualified technician to make the necessary repairs. Provide supporting documentation to our office for verification of the completed work.  ALL CEILINGS 1) Per DHSR-Construction's conversation with the local building inspector, the ceilings throughout the home did not meet 1-hour fire resistant construction. The ceiling were layed with only 1/2 inch drywall. Verify with the local building inspector the thickness of the additional drywall that will have to be installed to meet 1-hour fire resistant construction. Then contact a qualified technician to make the necessary installations. Provide supporting documentation to our office for verification of the completed work. It should be noted that in Family Care Homes all ceiling heights must meet the	C 174	C 174  The smoke detector in the Rear Office section of the home has been replaced and is functioning properly. It is confirmed it is connected to the other detectors in the home. Verification will be provided by November 25, 2015.  The access hatch in the Rear Office section of the home will be repaired to be flush with the ceiling and verification provided by November 25, 2015.  The picket on the hand rail to the steps of the Rear Office room will be replaced and verification provided by November 25, 2015.  The Wayne County Fire Inspector has been contacted regarding the ceiling construction. The Inspector stated he would return to the home to re-evaluate the ceilings. This will be completed and verification provided by November 25, 2015.	

PRINTED: 10/29/2015  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL096045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA LIVING ASSISTED CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 SE RAILROAD STREET PIKEVILLE, NC 27863</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 174	Continued From page 10 minimum 7'-6" height.	C 174	The facility co-owner, Travis Crocker, will complete quarterly inspections to monitor for any safety hazards or building maintenance needs to ensure repairs are completed.	